Focused Eye Care
NASHUA & MILFORD

Authorization for Release of Medication List
For the Purpose of Continuity of Care

Primary Care Doctor: _____

Address: _____

_____

Fax Number: _____

Patient Name: _____

Address: _____

_____

Phone Number: _____

Date of Birth: _____

The specific information I am requesting is my most updated **MEDICATION** list.

This information should be released to :

Focused Eye Care

505 West Hollis St. Suite 109

Nashua, NH 03062

Phone (603) 882-0311

Fax (603) 882-3020

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date that it is signed.

Signature: _____ Date: _____

Patient (Parent/Legal Guardian if a Minor)

Kelly M. MacDonald O.D. Scott D. Huffer O.D.|F.A.A.O. Sarah E. Jagatic O.D.
Philip S. Aubrey O.D. Anjelica M. Donnelly O.D. Kristen O. Bryant O.D. Kendra M. Phillis O.D.
505 West Hollis Street | Suite 109 | Nashua NH 03062 | P: 603.882.0311 | F: 603.882.3020 | abettervision.com
81 Mont Vernon Street | Milford NH 03055 | | 603.673.1330